MONTANA BOARD OF RADIOLOGIC TECHNOLOGISTS

301 South Park, 4th Floor
PO Box 200513
Helena Montana 59620-0513
Phone: (406) 841-2385 Fax: (406) 841-2305
Email: dlibsdrts@state.mt.us
Website: discoveringmontana.com/dli/bsd

LIMITED PERMIT
REQUIREMENTS AND APPLICATION INSTRUCTIONS

Applicants will be notified within 15 working days of receipt of a completed application as to the status.

Qualifications for Licensure: Applicants for a limited permit must:

- ✓ Completion of a 40-hour course approved by the board;
- ✓ Completion of additional courses to qualify for examination in each of the specified limited x-ray procedures as follows:
  - Chest – four (4) hours
  - Extremities – eight (8) hours
  - Spine – eight (8) hours
  - Skull – eight (8) hours
  - Abdomen – four (4) hours
  - G.I. tract fluoroscopy and associated overhead films – eight (8) hours
  - Positioning – eight (8) hours
- ✓ Be of good moral character;
- ✓ Be at least 18 years of age;
- ✓ Not be addicted to intemperate use of alcohol or narcotic drugs; and
- ✓ Passage of the general examination and passage of an examination for each specified x-ray procedure the applicant desires to be permitted to perform with a grade of 75% or better.

Fees:

- ✓ $45.00 Application fee
- ✓ $40.00 Original certificate fee
- ✓ $15.00 General examination fee
- ✓ $15.00 Each additional examination category

Application Procedures: A fully-completed application for licensure, signed and notarized, shall be submitted with the following documents:

- ✓ Photocopy of Birth Certificate or Drivers License.
- ✓ Copy of successful completion of a 40-hour board approved course.
- ✓ Copy of successful completion of additional courses to qualify for each specific examination.
- ✓ Application, certification and general examination fee in the amount of $100.00 plus $15.00 for each additional examination category. Make check or money order payable to the Board of Radiologic Technologists. All fees are non-refundable. Do not send cash.
- ✓ Three reference letters. Applicant must have been associated or known each reference for at least a year. Relatives may not be used as references.
- ✓ If currently or previously licensed in another state or jurisdiction, a License Verification/History must be sent to this office directly from those states or jurisdictions.

Examinations: The limited permit examination is a state administered examination required for those who perform x-ray procedures in specific categories. The exam is administered in Helena twice a year in coordination with the District 6 Health Care Learning Center's x-ray course. The exam may also be scheduled in the Board office throughout the year by appointment.

MONTANA BOARD OF RADIOLOGIC TECHNOLOGISTS

301 South Park, 4th Floor
PO BOX 200513
Helena Montana 59620-0513
Phone: (406) 841-2385, Fax: (406) 841-2305
Email: dlibsdrts@state.mt.us

APPLICATION FOR LICENSURE AS: (please check one)

☐ **RADIOLOGIC TECHNOLOGIST** **$90.00**

☐ TEMPORARY PERMIT (Pending Results of ARRT Exam) **$70.00**

☐ **LIMITED PERMIT** **$100.00 + $15.00 for each exam category**

PLEASE CHECK THE X-RAY CATEGORY EXAM (S) WHICH YOU ARE REQUESTING TO TAKE. ALL APPLICANTS MUST TAKE THE GENERAL EXAMINATION.

☐ Abdomen ☐ Extremities ☐ G.I. tract fluoroscopy & associated overhead films

☐ Chest ☐ Spine and Neck ☐ Skull

Exam Date:_____ Exam Location:_____

1. FULL NAME _____
   Last First Middle
2. OTHER NAME(S) KNOWN BY_____
3. PRESENT EMPLOYER:_____
4. EMPLOYER'S ADDRESS:_____
   Street or PO Box # City & State Zip Country
5. HOME ADDRESS: _____
   Street or PO Box # City & State Zip Country

   PREFERRED MAILING ADDRESS: ____ Home ____ Employer

   E-MAIL ADDRESS:_____
6. TELEPHONE: (_____)_____ (_____)_____ (_____)_____
   Business Home Fax
7. SOCIAL SECURITY NUMBER _____ FOREIGN ID NUMBER _____
8. DATE OF BIRTH _____ PLACE OF BIRTH _____ ☐ Male ☐ Female
9. LICENSE NAME_____
   (State your name as it should appear on the license if granted)
10. ARRT Certification: YES ☐ NO ☐

    Certificate Number:_____ Date Issued:_____ Expiration Date:_____

All applicants must answer the following questions. If you answer yes, give specific details (names of organizations, dates, reasons, and outcome) on a supplement sheet.

	YES	NO
11. Have you ever been denied the right to take this profession's licensing exam in any state? If yes, attach a detailed explanation.	☐	☐
12. Has a licensing agency ever taken adverse or disciplinary action against your license? If yes, attach a detailed explanation.	☐	☐
13. Has your license ever been forfeited or surrendered? If yes, attach a detailed explanation.	☐	☐
14. Has a complaint ever been made against you alleging unethical behavior or unprofessional conduct? If yes, attach a detailed explanation.	☐	☐
15. Have you ever been expelled from or asked to resign from any professional organization of which you were a member? If yes, please attach a detailed explanation.	☐	☐
16. Do you have criminal charges pending or have you ever pled guilty or been convicted of a crime (including a plea of no contest or deferred prosecution) relating to, or committed during the course of your professional practice, involving violence, use or sale of drugs, fraud, deceit, or theft, whether or not an appeal is pending? You may omit: (1) traffic violations, for which you paid a fine of $100.00 or less and (2) charges or convictions prior to your 16th birthday. If yes, attach a detailed explanation.	☐	☐
17. Have you ever been charged with fraud, formally or informally, in any legal proceeding? If yes, attach a detailed explanation	☐	☐
18. Have you any physical or mental condition which has in the past three years adversely affected your ability to practice this profession, including but not limited to, a contagious or infectious disease involving serious risk to the public? If yes, attach a detailed explanation	☐	☐
19. Have you within the last three years, used alcohol or any other mood-altering substance in a manner which adversely affected your ability to practice this profession? If yes, attach a detailed explanation.	☐	☐
20. Has any legal or disciplinary action been filed against you relating to or during the course of your professional practice? If yes, attached a detailed explanation.	☐	☐

Radiologic Technologist applicants GO TO question 24

Limited Permit applicants continue answering questions 21, 22 and 23

21. If taking the examination, do you have any physical or mental impairment(s) requiring special accommodation(s)? If yes, attach a detailed explanation.	☐	☐
22. Have you ever applied for or taken a Montana Limited Permit exam? If yes, attach a detailed explanation giving type of exam taken, date, and results.	☐	☐
23. Have you ever applied for or taken a Montana Limited Permit exam in any other state? If yes, attach a detailed explanation giving type of exam taken, date and results.	☐	☐

YES NO

24. Do you currently hold a license in another state as a radiologic technologist or limited permit? ☐ ☐
If yes, provide the following information;

License Type	State	License Number	Date Issued	Current? Yes/No

YOU MUST REQUEST A LICENSE VERIFICATION FROM STATES WHERE YOU CURRENTLY HOLD OR HAVE EVER HELD A LICENSE.

25. EDUCATION:

List all colleges, universities, or course(s) which you have attended and/or completed. Include copy of all diplomas or course completion certificates.

College \ University	Course	Date attended	# of Credits	
			Hours	Months

26. **REFERENCES OF CHARACTER,**

List three references of reputable citizens, unrelated to the applicant having personal knowledge of the applicant's moral character. Reference letters must accompany application.

Name/Relation	Address	Business
1.		
2.		
3.		

27. Experience: Provide all locations in which you have practiced in the last five (5) years.

Name of facility		
Address	City	State
Dates: From	To	

Name of facility		
Address	City	State
Dates: From	To	

Name of facility		
Address	City	State
Dates: From	To	

Name of facility		
Address	City	State
Dates: From	To	

Name of facility		
Address	City	State
Dates: From	To	

Name of facility		
Address	City	State
Dates: From	To	

Name of facility		
Address	City	State
Dates: From	To	

AFFIDAVIT

I authorize the release of information concerning my education, training, record, character, license history and competence to practice, by anyone who might possess such information, to the Montana Board of RADIOLOGIC TECHNOLOGISTS.

I hereby declare under penalty of perjury the information included in my application to be true and complete to the best of my knowledge. In signing this application, I am aware that a false statement or evasive answer to any question may lead to denial of my application or subsequent revocation of licensure on ethical grounds. I have read and am familiar with the applicable licensure laws of the State of Montana and instructions to applicants for licensing. I accept the rules and procedures outlined in these documents as the basis for my application.

_____ _____
Legal Signature of Applicant Date

Subscribed and sworn to me by this _____ day of _____, _____

At _____
City and State

_____
Notary Public

SEAL

_____
For the State of

My commission expires _____

MONTANA BOARD OF RADIOLOGIC TECHNOLOGISTS

301 South Park, 4th Floor
PO BOX 200513
Helena Montana 59620-0513
Phone: (406) 841-2385, Fax: (406) 841-2305
Email: dlibsdrts@state.mt.us
Website: discoveringmontana.com/dli/bsd

REFERENCE LETTER

Name of Applicant: _____

This form must be completed by a reference, unrelated to the applicant, who has been associated with the applicant for at least one (1) year. Three references are required. The reference letters must accompany the application.

1. How long have you known, worked or associated with this person? _____

   _____

2. Is this person, in your opinion of good moral character? _____

   _____

3. Does this person have good rapport with patients and co-workers? _____

   _____

Comments: _____

_____

_____

_____

_____

_____

_____

_____
Signed Date

_____
Address

_____
City

MONTANA BOARD OF RADIOLOGIC TECHNOLOGISTS

301 South Park, 4th Floor
PO BOX 200513
Helena Montana 59620-0513
Phone: (406) 841-2385, Fax: (406) 841-2305
Email: dlibsdrts@state.mt.us
Website: discoveringmontana.com/dli/bsd

REFERENCE LETTER

Name of Applicant: _____

This form must be completed by a reference, unrelated to the applicant, who has been associated with the applicant for at least one (1) year. Three references are required. The reference letters must accompany the application.

1. How long have you known, worked or associated with this person? _____

   _____

2. Is this person, in your opinion of good moral character? _____

   _____

3. Does this person have good rapport with patients and co-workers? _____

   _____

Comments: _____

_____

_____

_____

_____

_____

_____

_____
Signed Date

_____
Address

_____
City

MONTANA BOARD OF RADIOLOGIC TECHNOLOGISTS

301 South Park, 4th Floor
PO BOX 200513
Helena Montana 59620-0513
Phone: (406) 841-2385, Fax: (406) 841-2305
Email: dlibsdrts@state.mt.us
Website: discoveringmontana.com/dli/bsd

REFERENCE LETTER

Name of Applicant: _____

This form must be completed by a reference, unrelated to the applicant, who has been associated with the applicant for at least one (1) year. Three references are required. The reference letters must accompany the application.

1. How long have you known, worked or associated with this person? _____

   _____

2. Is this person, in your opinion of good moral character? _____

   _____

3. Does this person have good rapport with patients and co-workers? _____

   _____

Comments: _____

_____

_____

_____

_____

_____

_____

_____
Signed Date

_____
Address

_____
City